*Welcome to*

# Saylor & Murphy™ orthodontics

*The benefits of a happy, healthy smile are immeasurable!*
*Our goal is to help you reach and maintain optimal oral health.*
*Please fill out this form completely. The better we communicate, the better we can care for you.*

## About You

**Name:** _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/____/___ Age: ___ SS#: _____

**Home Address:** _____
Apt/Condo#

_____
City State Zip

How long at this address: _____

Previous Address *(If less than three years)*: _____
Apt/Condo#

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____) _____ Cell / Other #: _____

Wk #: (____) _____ Ext: _____ DL #: _____

**Employer:** _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

E-mail Address: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Present Dentist: _____

## Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: _____

Birthdate: ___/____/___ Age: ___ SS#: _____

**Emergency Contact**

His / Her Name: _____

Wk #: (____) _____ Ext: _____

## Dental Insurance

### Primary

Orthodontic Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/____/___ Insured's SS#: _____

Insured's Employer: _____

## Dental Insurance

### Secondary

Orthodontic Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/____/___ Insured's SS#: _____

Insured's Employer: _____

*I understand where appropriate, credit bureau reports may be obtained.*

*Continued on Back*

# Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (_____) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form: ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

_____

_____

Have you ever taken Phen-Fen?

Also known as Redux or Pondimin. ☐ Yes ☐ No

If so, when? _____

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding / Hemophilia | Y | N | Herpes / Fever Blisters |
| Y | N | AIDS | Y | N | High Blood Pressure |
| Y | N | Alcohol / Drugs | Y | N | HIV |
| Y | N | Anemia | Y | N | Hospitalized for Any Reason |
| Y | N | Arthritis | Y | N | Kidney Problems |
| Y | N | Artificial Bones / Joints / Valves | Y | N | Liver Disease |
| Y | N | Asthma | Y | N | Low Blood Pressure |
| Y | N | Blood Transfusion | Y | N | Lupus |
| Y | N | Cancer / Chemotherapy | Y | N | Mitral Valve Prolapse |
| Y | N | Colitis | Y | N | Pacemaker |
| Y | N | Congenital Heart Defect | Y | N | Psychiatric Problems |
| Y | N | Diabetes | Y | N | Radiation Treatment |
| Y | N | Difficulty Breathing | Y | N | Rheumatic / Scarlet Fever |
| Y | N | Emphysema | Y | N | Seizures |
| Y | N | Epilepsy | Y | N | Shingles |
| Y | N | Fainting Spells | Y | N | Sickle Cell Disease / Traits |
| Y | N | Frequent Headaches | Y | N | Sinus Problems |
| Y | N | Glaucoma | Y | N | Stroke |
| Y | N | Hay Fever | Y | N | Thyroid Problems |
| Y | N | Heart Attack / Surgery | Y | N | Tuberculosis (TB) |
| Y | N | Heart Murmur | Y | N | Ulcers |
| Y | N | Hepatitis | Y | N | Venereal Disease |

Please list any other serious medical condition(s) that you have ever had.

_____

_____

# Dental History

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

Have you ever had or been evaluated for orthodontic Treatment?

☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw point (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had an injury to your: Mouth Teeth Chin (Please Circle)

Do you have any speech problems? _____

Do you generally breathe through your mouth? ☐ Yes ☐ No

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform any necessary services that I may need during diagnosis and treatment, with my informed consent.

_____

Signature Date

# Allergies

Are you allergic to any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | Aspirin | Y | N | Erythromycin | Y | N | Penicillin |
| Y | N | Codeine | Y | N | Jewelry / Metals | Y | N | Tetracycline |
| Y | N | Dental Anesthetics | Y | N | Latex | Y | N | Other |

Please list any other drugs / materials that you are allergic to: _____

_____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

# MEDICAL HISTORY UPDATE

Has there been any change in your health since you last visit? Y N

If Yes, please explain. _____

_____

_____

Signature Date

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

_____

_____

Signature Date

Has there been any change in your health since you last visit? Y N

If Yes, please explain. _____

_____

_____

Signature Date

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

_____

_____

Signature Date